

# EXHIBIT A

Declaration of Omar Gonzalez-Pagan in support of  
Motion to Exclude Expert Testimony of Dr. Paul R. McHugh  
*Kadel v. Folwell*, No. 1:19-cv-00272-LCB-LPA (M.D.N.C.)

IN THE UNITED STATES DISTRICT COURT FOR

THE MIDDLE DISTRICT OF NORTH CAROLINA

\* \* \* \*

MAXWELL KADEL, et. al., \*

Plaintiffs \* Case No.:

DATE, FOULWELL, et al \* 1

## Defendants \*

\* \* \* \*

Remote videotaped

Remote videotaped deposition of PAUL  
McHUGH, M.D., was taken on Wednesday, September 8,  
2021, commencing at 9:40 a.m., before Allison L.  
Shearer, RPR, a Notary Public.

Reported By: Allison L. Shearer, RPR

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3 PAUL McHUGH, M.D.

4 BY MR. GONZALEZ-PAGAN

7

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1           Q.     Have there been any updates to your CV  
2 since you submitted your report?

3           A.     Only my recent publication in Commentary  
4 that was published in this -- the most recent issue  
5 of Commentary.

6           Q.     And was --

7           A.     You know, that's in my CV.

8           Q.     Did this publication pertain to gender  
9 identity?

10          A.     It did, yes.

11          Q.     What's the name of the publication?

12          A.     Oh, dear. It's -- let me -- just a  
13 second. I've got the magazine lying over here. It  
14 just -- it's not that I carried it with me. I just  
15 happen to have it in -- lying here. I'll get you  
16 the actual title.

17                 It's entitled Uninformed Consent: The  
18 Transgender Crisis and it's written by me and  
19 Gerard Bradley, the Professor of Law at Notre Dame.  
20 And it's in the September issue of Commentary.

21          Q.     And is Commentary a peer-reviewed

1 journal?

2 A. No.

3 Q. Is it a scientific journal?

4 A. No, it's a -- it's a journal of opinion.

5 Q. Thank you, Doctor. I know you have a  
6 long and sorted career so I -- I'm just going to  
7 try to go for some highlights today.

8 A. Nothing like living a long time; the  
9 curriculum vitae.

10 Q. Well, I can only hope to live this long  
11 so I appreciate it.

12 A. Yes.

13 Q. Where did you go to college?

14 A. I went to Harvard College.

15 Q. And when did you graduate?

16 A. 1952.

17 Q. And did you obtain a degree?

18 A. I did. I got a Bachelor's Degree from  
19 Harvard College, yes.

20 Q. And the Bachelor's Degree was in what?

21 A. It was in biology.

1           A.    A what?

2           Q.    Literature review. A new publication  
3    that is based on existing research out there, not  
4    --

5           A.    Okay.

6           Q.    Are you okay with my definitions for  
7    purposes of today?

8           A.    I'm sure we can work with them and work  
9    to make each other clear, yes. You might have to  
10   help me from time to time, but I'm -- I'm very  
11   happy with those distinctions, yes.

12          Q.    Understood. Thank you. You previously  
13   mentioned that you were an investigator, right?

14          A.    Yes.

15          Q.    As I understand it, you have conducted  
16   primary research into particular phenomena?

17          A.    Yes, I've -- I've conducted basic  
18   physiological research, as well as applied  
19   research. Yes.

20          Q.    Have you performed any primary research  
21   regarding gender dysphoria?

1           A. No, I -- I can't say that I've done --  
2 done primary research.

3           Q. Has your study of the -- of gender  
4 dysphoria been limited to review of existing  
5 literature and studies?

6           A. Well, it's also been meeting patients and  
7 talking with patients. It's a bit on personal  
8 experience. It's a review of what's available and  
9 personal experience with patients that come to  
10 Johns Hopkins and have other reasons for consulting  
11 me.

12          Q. Okay. With about how many transgender  
13 patients have you worked with over your career?

14          A. I suppose 30 or 35.

15          Q. When was the last time you worked with a  
16 transgender patient?

17          A. Yes. Oh, probably a few months ago;  
18 talked with one. Mm-hmm.

19          Q. So one of your two to three current  
20 patients is a transgender person?

21          A. No, it's -- it's not. I don't -- I don't

1 care for them in long-term. They or their families  
2 call me and ask me for -- sometimes to see the  
3 patient and sometimes to advise them about other  
4 representations for their treatment.

5                   And I will talk with them and give them  
6 my opinion about their situation and what seems to  
7 me to be the best use of the available treatments  
8 that are accessible to them. Yeah.

9                   Q. Understood. When these patients and/or  
10 their families come to you, have any of these  
11 patients been minors?

12                  A. Yes, most of them are minors that come to  
13 see me.

14                  Q. How about -- let me go back. You  
15 mentioned previously that you've worked with 30 to  
16 35 trans patients. Does this include these  
17 consultations?

18                  A. These kinds of consultations, yes. Yeah.

19                  Q. About how many of the 30 to 35 patients  
20 that you've worked with that were transgender have  
21 been minors?

1           A. Well, I'd say about 80 percent of them;  
2         20 percent have been adults.

3           Q. And to clarify, you have not provided  
4         them with long-term care. You have provided a  
5         consultation for specific questions that they had?

6           A. That's right. Mm-hmm.

7           Q. Let's go back. Have you performed any  
8         primary research relating to transgender people?

9           A. Again, as I say, I'm not quite sure what  
10         you mean, but I have not -- importantly, what I  
11         have not done is made a -- a collection of my  
12         experiences with patients and pulled them together  
13         into a -- into a particular article or things of  
14         that sort.

15           I've used more secondary information that  
16         I've acquired by seeing what's being asked for the  
17         patients and what's in the literature. Yeah.

18           So I suppose I have not actually produced  
19         primary research and if I had, I would have, of  
20         course, published and we could have pointed to it.

21           Q. Okay. Thank you. And that's what I'm

1 getting at. So I -- I -- we don't need to make  
2 this overly difficult, right. So just so we  
3 understand each other, that's -- that's what I'm  
4 getting at, right.

5 I'm asking whether you have defined and  
6 conducted a study, whether clinical, observational,  
7 longitudinal, resectional, having to do with gender  
8 dysphoria or transgender people?

9 A. No. No, Mr. Gonzalez, I did not.

10 Q. Okay. Thank you. I have your CV in  
11 front of me. There are a ton of publications and  
12 -- over a long career.

13 A. Yeah.

14 Q. I understand that there are some of these  
15 publications that are peer-reviewed publications;  
16 is that right?

17 A. Yes. Yes, many of them. Yes.

18 Q. Are any of your peer-reviewed  
19 publications regarding gender dysphoria?

20 A. No -- well, yes. Yes, one of them. One  
21 of them in the -- in Nature Medicine entitled

1       Witches, Multiple Personalities, and other  
2       things. Yes, that's a peer-reviewed journal.

3                  And in it I lay out my opinions about the  
4       transgender phenomenon. You'll find it in the  
5       Nature Medicine article.

6       Q.     Do you recall about when this article was  
7       published?

8       A.     In the 1990s somewhere. I've had a long  
9       experience discussing these matters and I was  
10      talking about it back in the '90s. You'll find it  
11      in my CV, if you look.

12      Q.     Oh, no, I am looking. So just --

13      A.     I'm --

14      Q.     I was just going through it. Just going  
15      through it just to kind of --

16      A.     --

17      Q.     -- to make sure we --

18      A.     --

19      Q.     -- we're talking about the same... So  
20      this is in Nature Medicine, right?

21      A.     Right. That's right.

1           Q.     Is this the article, Witches, Multiple  
2     Personalities, and Other Psychiatric Artifacts?

3           A.     That's right.

4           Q.     Okay.

5           A.     That's the one.

6           Q.     And is this article based on primary  
7     research?

8           A.     No, it's involved in a -- a consideration  
9     of what was the themes at that time about the  
10    transgender/transsexual treatments and the  
11    involvement at Johns Hopkins with it. It was a --  
12    it was a commentary on the state of the literature  
13    then that was published in this peer-reviewed  
14    journal.

15          Q.     Thank you. Aside from the article in  
16    Nature Medicine in 1995, do you have any other  
17    peer-reviewed publications regarding gender  
18    dysphoria?

19          A.     No, I don't.

20          Q.     Aside from the article --

21          A.     I just have my opinion really from the

1 one that I expressed in that article. I beg your  
2 pardon. I'm sorry, sir. I interrupted you.

3 Q. No. No. It's no problem. Aside from  
4 the article in Nature Medicine in 1995, do you have  
5 any peer-reviewed publications relating to  
6 transgender people?

7 A. No.

8 Q. And aside from the article in Nature  
9 Medicine in 1995, do you have any peer-reviewed  
10 publications relating to gender identity?

11 A. No. No, sir.

12 Q. You also have a number of non-peer  
13 reviewed publications, right?

14 A. Yes.

15 Q. Are any of your non-peer reviewed  
16 publications regarding gender dysphoria?

17 A. Yes, some of them are. Yes.

18 Q. Which are those publications?

19 A. Which are they?

20 Q. Yeah.

21 A. Oh, good grief. There are -- there are

1       that is my first venture into this area. Yeah.

2           Q.     So your first venture into publishing in  
3     this area was with *Psychiatric Misadventures*?

4           A.     That's right.

5           Q.     That was back in 1992?

6           A.     That's right.

7           Q.     All right. Have you ever diagnosed a  
8     person with gender dysphoria?

9           A.     Yes.

10          Q.     How many times?

11          A.     Oh, as I said, most -- my 30 patients, 35  
12     patients. I suppose most of them had gender  
13     dysphoria. So I suppose I thought they were all  
14     involved with it in some way or another. You know,  
15     they varied in intensity. Some of them were  
16     not. Some of the adults didn't have dysphoria and  
17     -- and were just looking to me to ask what I  
18     thought the outcome might be if they proceeded with  
19     their transsexual behavior and sought hormonal and  
20     surgical treatment.

21          Q.     And when you met with these patients, you

1       were not seeing them long-term we've established,  
2       right?

3           A.    That was right. I wasn't seeing them  
4       long-term.

5           Q.    So were you providing them with care for  
6       their gender dysphoria?

7           A.    I was providing -- providing them with  
8       advice about what I thought would do the best for  
9       them.

10          Q.    Okay. And as I understand a little bit  
11       of the conversation, you think some of them had and  
12       some of them hadn't had gender dysphoria, but did  
13       you ever formally diagnose any of these patients?

14          A.    By formally diagnosing that I wrote -- I  
15       wrote the patient up in some kind of way for the  
16       records in the hospital, no. I only saw them,  
17       advised them, and wrote about my advice to them.

18          Q.    Were your consultations with these  
19       patients like one-offs or did it involve multiple  
20       visits?

21          A.    Well, several of them involved several

1 visits. Not -- I wouldn't say multiple as though  
2 it was ongoing caregiving, but sometimes they had  
3 questions and sometimes the people I referred them  
4 to had questions and we talked back and forth a  
5 couple of times, yes.

6 Q. When you -- when you were presented with  
7 any of these patients, did you ever refer them to a  
8 provider that would provide gender-affirming care?

9 A. I -- I referred them sometimes. A couple  
10 of them I referred to somebody who could -- who I  
11 thought was equipped to offer them treatment, but  
12 not gender -- not necessarily gender-affirming,  
13 although they might when they -- when they reviewed  
14 the patient themselves come to that conclusion.

15 I referred them to particular -- a couple  
16 of them to Dr. Fred Berlin here at -- at Johns  
17 Hopkins who was a student of sexual behavior and  
18 offered them treatment.

19 Q. To whom besides Dr. Berlin did you refer  
20 patients to?

21 A. It was only Dr. Berlin.

1           Q.     Is it fair to say that you're not -- have  
2     not provided care to a transgender patient  
3     diagnosed with gender dysphoria?

4           A.     It's fair to say that I have not provided  
5     long-term care, no. That's correct. Mm-hmm.

6           Q.     Is it fair to say that you have not  
7     provided care -- long-term care to a transgender  
8     patient diagnosed with gender identity disorder?

9           A.     That's fair to say, at least  
10    personally. You have to remember, I was overseeing  
11    a -- for a while -- a sexual behavior unit in which  
12    care was being offered to these patients and my  
13    responsibility was to oversee that and recognize  
14    and advise as to the direction it was going in, but  
15    that experience was early in the 1970s.

16          Q.     And this is in your capacity as  
17    psychiatrist-in-chief --

18          A.     That's right.

19          Q.     -- at Johns Hopkins --

20          A.     That's right, yes.

21          Q.     -- Hospital? And your tenure as

1           Q.     Have you overseen any clinic providing  
2 gender-affirming care between 1979 to today?

3           MR. KNEPPER: Objection; form.

4           THE WITNESS: As I -- as I say, I don't  
5 like this term gender-affirming care. I have  
6 overseen clinics, that clinic in particular and  
7 it's later development in the offering of other  
8 forms of treatment other than physical forms of  
9 treatment --

10          BY MR. GONZALEZ-PAGAN:

11          Q.     Right.

12          A.     -- for the transgendered and transsexual  
13 patients. Yes.

14          Q.     Okay.

15          A.     But that was -- that was -- that was it,  
16 sir. Yeah.

17          Q.     All right. Just because there was an  
18 objection and just to clarify the record, in your  
19 capacity as a physician at Johns Hopkins, have you  
20 overseen or directed any clinic providing medical  
21 and surgical interventions for the treatment of

1 gender dysphoria since 1979?

2 A. No. I --

3 Q. Thank you.

4 A. -- think the fair answer to that is  
5 no. I think that's fair.

6 Q. You mentioned that your conclusion that  
7 there's a uni-directed Transgender Treatment  
8 Industry was based on your clinical observations --  
9 well, was based on your conversations with 30 to 35  
10 transgender patients, your experience with the  
11 sexual behaviors clinic at Johns Hopkins from 1975  
12 to 1979, and what you've heard from other people;  
13 is that right?

14 A. Once again, you stop at 1979 as though I  
15 was stopped from that point on seeing any kinds of  
16 an understanding from other kinds of patients that  
17 came then, even though we were not offering these  
18 so-called treatments, that we didn't oversee and  
19 observe what the treatments had been that brought  
20 them to us and for which we were offering an  
21 alternative. No. So --

1 conferences that were -- out of conferences that  
2 would be taking place around the Sexual Behavior  
3 Clinic.

4 Q. Okay. But not patients that -- let me  
5 rephrase that. Your experience with regards to  
6 patients diagnosed with gender identity disorder or  
7 gender dysphoria is limited to this 30 to 35  
8 patients; is that right? Direct experience.

9 A. No. No. My -- my direct personal  
10 experience out of the care would be that, yes.

11 Q. Right.

12 A. But my oversight gave me consultation and  
13 responsibility for hundreds of patients that were  
14 flowing through that clinic both before we stopped  
15 offering the surgical treatment and afterwards I  
16 would say.

17 Q. These are patients that were being seen  
18 by other physicians that were under your purview?

19 A. That's right.

20 Q. Okay. Is the term Transgender Treatment  
21 Industry a term of art?

1           A. That's okay.

2           Q. -- have practiced in this field for a  
3 while. So it was new.

4           A. That's -- that's wonderful,  
5 Mr. Gonzalez. I appreciate your pointing this out.  
6 Mm-hmm.

7           Q. So I will ask this: Is it a term that  
8 you commonly use?

9           MR. KNEPPER: Objection.

10           THE WITNESS: No. I'm using it more and  
11 more frequently now and as I'm more and more  
12 impressed by the single-mindedness of the  
13 treatments being offered, I -- for example, I even  
14 think this idea, the very concept of affirming,  
15 gender-affirming treatment, is an expression of  
16 that industrial movement. I -- I don't think  
17 there's anything affirming about any of this.

18 BY MR. GONZALEZ-PAGAN:

19           Q. Well, isn't the idea that you are  
20 affirming the person's identity?

21           A. No, it's affirming the patient's

1 misdirection and therefore affirming isn't the  
2 correct word I don't think, but -- but, you know,  
3 we could -- we could talk about that just as it's  
4 -- it has become a -- a term of art within the  
5 industry, but it -- it's -- it's an easily  
6 challengeable word.

7 Q. When did you first hear the term  
8 Transgender Treatment Industry?

9 A. Oh, dear. As I say, I --

10 MR. KNEPPER: Objection; asked and  
11 answered.

12 THE WITNESS: That's right. I've got no  
13 idea when -- when I heard it or if I heard it from  
14 somebody else or I thought it up myself in the  
15 process of watching what was happening.

16 I was trying to characterize in words  
17 what I thought was happening and the huge increase  
18 in patients that were making the claims that they  
19 were of the opposite sex, just the building up of  
20 some 4,000 percent more women, young women,  
21 reporting this. It was just --

1 overreliance on the DSM?

2           A. Do I opine? I think that part of the  
3 problem is DSM for all of the -- our woes in  
4 psychiatry right at the moment and many of the  
5 arguments we get into relate to the fact that the  
6 DSM is the so-called bible of our discipline rather  
7 than a true classification of -- of mental  
8 disorders like we have a true classification of  
9 medical disorders.

10          Q. Sure. And to clarify, the DSM is the  
11 Diagnostic and Statistical Manual of Mental  
12 Disorders published by the American Psychiatric  
13 Association; is that right?

14          A. Yes, it is. Yes.

15          Q. Okay. Let me ask you: Do you -- is  
16 gender dysphoria a very real condition? Well, let  
17 me scratch that. Is gender dysphoria a real  
18 condition?

19          A. Well, it's certainly a feeling that  
20 patients report. So this concept --

21          Q. Well --

1           A. This concept of -- look, this is just  
2 what I do every day, Mr. Gonzalez. This concept of  
3 a real thing versus a feeling or an attitude or an  
4 assumption are all important things to distinguish  
5 because those things differ in relationship to  
6 their generation.

7           Something that is a condition like heart  
8 failure or pneumonia can be attributed and called a  
9 condition because it has a common generation and a  
10 -- a common outline.

11           Gender dysphoria like many other sort of  
12 senses and feelings can come from all kinds of  
13 different directions and therefore it's best  
14 thought of as a state of mind. Let's put it that  
15 way. It's a state of mind.

16           Q. Well, how would you define gender  
17 dysphoria?

18           A. Well, as I say, it's a state of mind in  
19 which a person has come to feel somehow from -- for  
20 reasons that we don't quite understand that he or  
21 she belongs to the opposite sex and is discomforted

1 by the fact that his body and -- and the world  
2 around him does not agree with that.

3 Q. Would you agree that there are people  
4 that experience distress due to the misalignment of  
5 their perceived gender identity and their sex  
6 assigned at birth?

7 A. All of those things are -- are terms that  
8 I would debate with you, each one of them alone.  
9 You don't assign a sex at birth. You discover sex  
10 -- sex at birth.

11 There are plenty of people though in the  
12 world who right now for a variety of reasons, many  
13 of which are still to be discovered, find  
14 themselves arguing that they don't feel comfortable  
15 in their body, their sexual body.

16 Q. How is the sex of a child determined at  
17 birth?

18 A. Well, it's usually very -- about 99  
19 percent of them are determined by the parents of  
20 the body and it turns out to be quite correct in  
21 relationship, both to the chromosomal --

1           Q.   Would you then -- would you consider the  
2 ICD, the International Classification of Diseases,  
3 to be a classification?

4           A.   Yes, that is and when you compare the  
5 two, you can see the difference. You have to be a  
6 physician to read ICD and understand it.

7                 You have -- you don't have to be a  
8 physician -- as you know, anybody can read DSM and  
9 it's even said that -- that authors use DSM to  
10 characterize some of the characters they're going  
11 to put in their fiction.

12          Q.   Okay. Would you agree that the DSM,  
13 however, does not prescribe treatment?

14          A.   Yes. Yes. Yes. I -- I suppose it  
15 doesn't.

16          Q.   You describe the DSM as "essentially a  
17 dictionary based on consensus-seeking voting  
18 methodologies rather than evidence-based" --  
19 apologies -- "rather than evidence-seeking  
20 scientific methodologies."

21          A.   Yes. Yes.

1 Q. -- view of the DSM.

2 A. Okay.

3 Q. Would you say that the DSM is a reliable  
4 tool for the diagnosis of particular conditions,  
5 but that it does not --

6 A. It's --

7 Q. -- explain the causes of said condition?

8 A. I'm -- I'm afraid you're using the term  
9 reliable in a way that -- that you and I ought to  
10 be clear about. It is reliable in the sense that  
11 other people can agree that that term applies here,  
12 but it is not valid in the sense of understanding  
13 what the condition really is between the people,  
14 okay.

15 So often the word reliable as used by  
16 other people outside of science is used as a way of  
17 saying well, if this is a reliable diagnosis, it  
18 must be a correct diagnosis or an understanding  
19 diagnosis. I want to make a point that this is  
20 only to permit people to use the same words for  
21 patients that look alike.

1           Q.     Understood. So in diagnosing patients,  
2 without delving into the treatment and/or causes  
3 for said patient's condition, does the DSM serve to  
4 identify a diagnosis?

5                   MR. KNEPPER: Objection; form.

6 BY MR. GONZALEZ-PAGAN:

7           Q.     I guess what I'm trying to get at here  
8 is: What would you use to diagnose a  
9 patient? Like isn't it -- isn't the purpose of the  
10 DSM to come up with some common language for mental  
11 health practitioners?

12          A.     The purpose of DSM is to make sure that  
13 people are referring to patients that look alike,  
14 but it is not its purpose to presume that those  
15 things that look alike have the same sources and  
16 the same natures, okay?

17          Q.     Understood.

18          A.     I mean, I wrote an -- an article in the  
19 New England Journal with Dr. Slavney that, you  
20 know, made reference to it before and what I was --  
21 what I wanted to use for the title is What is

1       but if you look at it in general medical terms, the  
2       ICD in cardiology and all those, that is a real  
3       classification and you have to be a doctor to  
4       really understand it.

5           Q.     Okay. The ICD defines gender  
6       incongruence as "a marked and persistent  
7       incongruence between the gender felt or experienced  
8       and the gender assigned at birth" Are you aware of  
9       that?

10          A.     I'm not, but it doesn't surprise me.

11          Q.     Okay.

12          A.     It uses all the usual words, including  
13       the word gender.

14          Q.     It also uses assigned at birth.

15          A.     Yeah. Exactly. It -- it says that,  
16       too. It -- it will change.

17          Q.     Okay. Going back to -- to the statement  
18       that you made in your report --

19            MR. GONZALEZ-PAGAN: And we can -- we can  
20       take off -- take it off the screen.

21            THE WITNESS: Okay.

1 BY MR. GONZALEZ-PAGAN:

2 Q. You indicated that the DSM is not based  
3 on evidence-seeking scientific methodologies; is  
4 that right?

5 A. No, it's -- it's based on appearances.  
6 It says so.

7 Q. Okay. Are you aware that the revision of  
8 the DSM involves a multi-year process?

9 A. No, the DSM's fifth edition has tried to  
10 be -- to modify it just as they did in DSM-4, but  
11 -- DSM-3, but it still uses the same methodology,  
12 the same -- same method and with the assumption  
13 that you had to find reliability and then through  
14 reliability you might get to validity and  
15 intelligibility didn't matter.

16 Q. Okay. Are you aware that the revision of  
17 the DSM involves research evaluation, publication  
18 of whitepapers, peer-reviewed articles, and  
19 scientific conferences?

20 A. Yes, I am and I'm also aware that DSM has  
21 decided that it still would use the original

1 approach that -- that it took, that the sciences  
2 and the things of that sort were -- that they'd  
3 employed were methods that employed ways of  
4 demonstrating that they could still find  
5 reliability in the sense of consistency in  
6 diagnosis.

7                 Nothing -- nothing radically changed  
8 between DSM-3 and DSM-5 in relationship to the  
9 method that was being employed.

10               Q. Are you aware that there were -- revision  
11 of the DSM involves the establishment of task force  
12 and workgroups that review scientific literature?

13               A. Of course I am, yes.

14               Q. Are you aware that the revision of the  
15 DSM involves the establishment of scientific review  
16 committee that evaluated and provided guidance on  
17 the strength of evidence of any proposed changes?

18               A. Yes.

19               Q. Would it be fair to say then that the  
20 development of the DSM does involve the evaluation  
21 of scientific information and literature?

1           A. Well, that word scientific is being used  
2 -- you're using it in a -- in a very broad  
3 sense. It is useful and -- and DSM does use  
4 scientific information to encourage its own  
5 reliability studies. That's scientific, but it's  
6 not necessarily related to validity.

7                 And nothing has been done in relationship  
8 to validating the distinctions of any of these  
9 conditions in relationship to their sources, their  
10 generative sources.

11           Q. If I'm understanding correctly where  
12 you're coming from here, and just correct me if I'm  
13 wrong, is a broader critique of the DSM in almost  
14 what its purpose is, that rather than serve as a  
15 guide to come up with a diagnosis based on  
16 observable phenomena or criteria, it should be more  
17 explanatory as to the nature and cause of a  
18 particular condition?

19           A. Yes, a real classification as in general  
20 medicine would. And psychiatry should be working  
21 towards a classification that rests itself in the

1       distinctions amongst conditions related to their  
2       generation.

3               This is -- this is a very simple  
4       scientific concept that extends far back into  
5       scientific studies, but the field guide step, which  
6       is the step that DSM is, is considered only a step  
7       on the pathway to an ultimate coherent  
8       classification or a method. So...

9               Q.     Let me ask you this --

10          A.     Yeah.

11          Q.     -- is there any -- is there any  
12       classification system currently in existence that  
13       -- that operates that way with regards to mental  
14       disorders?

15          A.     Yes, there is.

16          Q.     Which one?

17          A.     The one that I employ at Johns Hopkins  
18       and we employ, the so-called Perspectives of  
19       Psychiatry. If you read that, you'll see that it  
20       strives to -- to generate a coherent distinction  
21       amongst conditions that relate to what a person has

1       is a diseases, to what a person is is a  
2       personality, what a person encounters is a life in  
3       a life, and that what a person is doing is a  
4       behavior.

5                  And it wants to make a distinction and it  
6       struggles to show the data that relates to those  
7       distinctions between diseases, dimensions,  
8       behaviors, and life stories or life encounters.

9       Yes. And where --

10      Q.     And the -- this is the Perspective in  
11     Psychiatry that was published in the 1980s; is that  
12     right?

13      A.     Yes. And -- and the second edition in  
14     the 1990s I believe. Yeah.

15      Q.     And second edition in 1998?

16      A.     Yeah, that's right.

17      Q.     Is this the -- is Perspective in  
18     Psychiatry the -- commonly used within the field of  
19     psychiatry to make diagnoses?

20      A.     It's commonly used at Johns Hopkins all  
21     the time and it's making headway elsewhere.

1 Q. All right.

2 A. I don't know how much it's going  
3 anywhere, but -- let's put it this way. That --  
4 you asked is there an alternative classificatory  
5 system and I'm saying yes, there is this one.

6 Q. But is it widely -- what I'm asking as a  
7 follow up -- I accept your answer.

8 A. Yes.

9 Q. Is it -- is it the widely-used system of  
10 classification used in the field of psychiatry?

11 A. I wish it were more widely used and it  
12 will eventually be so, but right now it is a -- a  
13 proposal. You asked me to begin with is there  
14 anything out there and actually --

15 Q. No. No. Yeah. I appreciate it. I  
16 mean, I guess what I'm trying to get at is --

17 A. Okay.

18 Q. There -- there is --

19 A. You know, the real problem here is that  
20 once you have a field guide, it's very hard to get  
21 somebody to do something else because it requires

1 look at it in relationship to disorders of the skin  
2 or the heart or the -- the stomach or something,  
3 will show you what a real classification is like.

4 Q. Okay. And the definition of gender  
5 incongruence in the ICD is quite similar to the  
6 definition of gender dysphoria in the DSM; is that  
7 right?

8 A. That's right. It uses all the same stock  
9 phrases.

10 Q. In your report you make reference to a  
11 statement by Thomas Insel, the then director of the  
12 National Institute of Mental Health, that it --  
13 that the NIMH would be reorienting its research  
14 away from the DSM categories. Do you recall that?

15 A. I do. I recall that, yes.

16 Q. Okay. Do you understand that Dr. Insel  
17 -- Dr. Insel's statement pertained to the NI -- the  
18 NIMH establishing the Research Domain Criteria  
19 project?

20 A. Yes, I do.

21 Q. Okay. And you understand that

1 Dr. Insel's statement pertaining to the Research  
2 Domain Criteria project reflects a long-term goal  
3 to understand mental illness as disorders of brain  
4 structure and function?

5 A. I -- I understand that, yes.

6 Q. Okay. Were you aware that two weeks  
7 after the statement that you referenced with  
8 regards to Dr. Insel he issued a joint statement  
9 with the American Psychiatric Association stating  
10 that "The American Psychiatric Association's  
11 Diagnostic and Statistical Manual of Mental  
12 Disorders along with the International  
13 Classification of Diseases represents the best  
14 information currently available for clinical  
15 diagnosis of mental disorders"?

16 A. I wasn't aware of that, but it doesn't  
17 surprise me.

18 Q. Okay.

19 MR. GONZALEZ-PAGAN: Let's mark up the  
20 joint statement, Lauren.

21 (Whereupon, Exhibit No. 6 was marked for

1 identification.)

2 MR. GONZALEZ-PAGAN: Just to preview,  
3 John, I think what I'm going to do is finish with  
4 this exhibit and line of questioning and then we  
5 can do a lunch break, if it works for people.

6 MR. KNEPPER: That was going to be my  
7 thought, Mar, is sort of get the DSM conversation  
8 completed, if -- if that's -- if that's where we're  
9 close, and then we can take a lunch break.

10 MR. GONZALEZ-PAGAN: Yeah, that sounds  
11 good. Let's do that. All right. If we can zoom  
12 in a little bit, Lauren. All right.

13 BY MR. GONZALEZ-PAGAN:

14 Q. Dr. McHugh, I'm showing you what's been  
15 marked as Exhibit 6. It is a news release by the  
16 American Psychiatric Association issued on behalf  
17 of Thomas R. Insel, M.D., Director of NIMH, and  
18 Jeffrey A. Lieberman, M.D., president-elect of the  
19 APA. Is that right?

20 A. Yeah.

21 Q. Okay. Let's just go to the second

1 paragraph. And we can zoom a little bit into that.

2 A. Yes. Yes, sir. Okay.

3 Q. I'm just going to read it. "Today the  
4 American Psychiatric Association's Diagnostic and  
5 Statistic Manual of Mental Disorders along with the  
6 International Classification of Diseases represents  
7 the best information currently available for  
8 clinical diagnosis of mental disorders.

9 Patients, families, and insurers can be  
10 confident that effective treatments are available  
11 and that the DSM is the key resource for delivering  
12 the best available care.

13 The National Institute of Mental Health  
14 has not changed its position on DSM-5. As the NIMH  
15 Research Domain Criteria project website states,  
16 the diagnostic categories represented in the DSM-4  
17 and the International Classification of Diseases 10  
18 containing virtually identical disorder codes  
19 remain the contemporary consensus standard for how  
20 mental disorders are diagnosed and treated." Did I  
21 read that correctly?

1           A. You did.

2           Q. Okay. And just to clarify, you were not  
3 aware about this joint statement by Dr. Insel with  
4 the APA?

5           A. I wasn't aware of it, but there you are.

6           Q. Do you think it is important information  
7 to put into context the statement that you included  
8 from Dr. Insel with regards to the DSM?

9           A. No.

10          Q. Why not?

11          A. Well, because I think that it's still  
12 discussing -- he discussed when he was at the NIH  
13 the reasons why they were dissatisfied with the DSM  
14 and he's here just reassuring everybody that what  
15 he has done shouldn't be taken as radical as many  
16 people have taken it. You know, he was --

17          Q. Well, I --

18          A. He was -- he was saying at one time that  
19 -- at the time when he was proposing the Research  
20 Diagnostic Domain Criteria, that something needed  
21 to change.

1           What he's saying here is although  
2 something needs to be changed, what they -- what he  
3 believes now is that this remains the standard for  
4 which mental diagnoses are diagnosed and treated.  
5 But if you tried to get a research project that was  
6 resting only on that rather than a reference to the  
7 Research Domain Criteria, you wouldn't get it from  
8 the NIH. It doesn't say that as well.

9           Q.    Okay. Thank you. If we go down a little  
10 bit more closer to the bottom, just reading the  
11 last three sentences of the -- what appears to be  
12 the third-to-last paragraph.

13          A.    Yeah.

14          Q.    It starts "RDoC is a new comprehensive  
15 effort to redefine the research agenda for mental  
16 illness. As research findings begin to emerge from  
17 the RDoC effort, these findings may be incorporated  
18 into future DSM revisions and clinical practice  
19 guidelines, but that is a long-term undertaking.

20                 It will take years to fulfill the promise  
21 that this research effort represents for

1 transforming the diagnosis and treatment of mental  
2 disorders. Did I -- did I read that correctly?

3 A. Yeah.

4 Q. Okay. And just to sum, the position of  
5 the NIMH seems to be we want to move towards a more  
6 research-based understanding of mental disorders  
7 and their causes, but we're not discrediting the  
8 DSM as a method for diagnoses at the time at the  
9 present?

10 A. I'm -- yes. Yes. And your point?

11 Q. Great.

12 MR. GONZALEZ-PAGAN: Okay. All right.  
13 That looks good. I think we can -- we can take it  
14 off, Lauren. We'll take a break for lunch.

15 THE WITNESS: Okay.

16 MR. GONZALEZ-PAGAN: Would an hour  
17 suffice?

18 THE WITNESS: That would be wonderful.  
19 But, you know, whatever -- whatever fits with you.

20 MR. GONZALEZ-PAGAN: Well, I'm asking --  
21 I'm asking everybody here, including you.

1                   MR.GONZALEZ-PAGAN: So let's do this.

2 Let's come back at 1:15.

3                   THE WITNESS: 1:15? Fine. Fine with me.

4                   MR. GONZALEZ-PAGAN: And we'll reconvene  
5 then.

6                   MR. McINNES: All right.

7                   THE WITNESS: Okay.

8                   VIDEOGRAPHER: Okay. We are going --

9                   THE WITNESS: That will be --

10                  VIDEOGRAPHER: We are going off the  
11 record. The time is 12:11 p.m.

12                  (Whereupon, a brief recess was taken.)

13                  VIDEOGRAPHER: We're back on the  
14 record. The time is 1:15 p.m. This is media  
15 number three.

16 BY MR. GONZALEZ-PAGAN:

17                  Q. Dr. McHugh, earlier you had testified  
18 about how for some of the 30 to 35 transgender  
19 patients for whom you've consulted you've referred  
20 some of these to Fred Berlin --

21                  A. Yeah.

1           Q. -- psychiatrist at Johns Hopkins himself;  
2 is that right?

3           A. Yes. Right. That's right.

4           Q. Okay. And my understanding is that he is  
5 a director at the Sex and Gender Clinic at Johns  
6 Hopkins Hospital?

7           A. He is now, yes. Mm-hmm.

8           Q. Okay. And my understanding is that the  
9 Sex and Gender Clinic works in collaboration with  
10 the Transgender Health Center that has been now  
11 established at Johns Hopkins; is that right?

12          A. They do. They collaborate with them,  
13 yes. Mm-hmm.

14          Q. Okay. Thank you. Let's go to paragraph  
15 nine of your report.

16           MR. GONZALEZ-PAGAN: Lauren, if we could  
17 pull the report up, that would be great.

18           THE WITNESS: Uh-huh.

19 BY MR. GONZALEZ-PAGAN:

20          Q. In this paragraph, Dr. McHugh, you speak  
21 of the Transgender Treatment Industry as a

1 comes out of a checklist out of DSM. You satisfy  
2 these criteria; therefore, you get this treatment.  
3 Not a good solid workup. I mean, that's what we  
4 were talking about this morning.

5 Q. Would you agree that there are -- there  
6 are some people for whom their gender  
7 identification is inconsistent with the sex they  
8 were determined to be at birth and that they don't  
9 have any other co-occurring conditions?

10 A. I believe that all of these patients -- I  
11 hold that all of these patients have a disorder of  
12 assumption and that although it's conceivable that  
13 some of them may well have a genetic -- some  
14 chromosomal abnormality, that's what needs to be  
15 demonstrated, not -- not simply presumed. And  
16 that's what I'm objecting to; they're often  
17 presumed.

18 So I -- I have no idea whether there  
19 might -- and how many might be due to a genetic  
20 cause and -- because nobody has given me any  
21 evidence for any of it.

1 able to independently observe particular -- in  
2 their meetings with their patient particular  
3 behaviors and/or expressions?

4 MR. KNEPPER: Objection.

5 THE WITNESS: Obviously, that's part of  
6 my job as a teacher and a builder of the Department  
7 of Psychiatry is to make clinicians of the sort  
8 that would look for more than one hypothesis for  
9 the explanation of something that was reliably  
10 recognized, but not validly understood. Yes,  
11 that's exactly what we're trying to do.

12 BY MR. GONZALEZ-PAGAN:

13 Q. Okay. So as I understand your critique,  
14 and correct me, part of your critique, is that the  
15 so-called Transgender Treatment Industry, somebody  
16 comes in, says this is my gender identity, and  
17 they're immediately referred to for medical and  
18 surgical care based on that self-report?

19 A. Yeah. Well -- yes. That's my objection  
20 to it. I find that it was very often, very often  
21 that the patients weren't sufficiently studied

1 before a prescription was offered.

2           They met criteria for gender dysphoria in  
3 DSM terms and with that, the presumption was  
4 there's one standard treatment and that is offered  
5 to them and that's what I'm -- one of my main  
6 objections here.

7           Q.    Okay. So would your objection then be  
8 moot if you were informed that a clinician actually  
9 engaged in a detailed psychiatric interview and  
10 various visits with the patient in order to  
11 corroborate their self-report?

12           MR. KNEPPER: Objection to form.

13           THE WITNESS: I would be helped along the  
14 way. I would like to know what it is, especially  
15 if a radical treatment which the benefits are  
16 uncertain as often, you know.

17           After all, I have -- I have seen doctors  
18 who have said they've done a good study of a  
19 patient and said that probably a frontal lobotomy  
20 would help them. After all, I go back a long  
21 while.

1 I wanted to encourage him to go on with that  
2 because I had my serious doubts about this matter.

3 Q. What gave rise -- what gave rise to your  
4 doubts?

5 A. Well, just I saw some of the patients and  
6 they looked -- and this -- this is before I came to  
7 Baltimore, but I saw some of them in Oregon and I  
8 -- I thought they looked like caricatures of -- of  
9 women and I very much doubted that they were  
10 benefiting from it, but I wasn't certain.

11 Q. Don't you think it is pejorative to refer  
12 to transgender women as caricatures of women?

13 A. No, I don't think it's pejorative if it's  
14 true.

15 MR. KNEPPER: Objection; form.

16 MR. GONZALEZ-PAGAN: Lauren, let's mark  
17 Exhibit -- that's Dr. McHugh's Psychiatric  
18 Adventure -- Misadventures.

19 (Whereupon, Exhibit No. 7 was marked for  
20 identification.)

21 BY MR. GONZALEZ-PAGAN:

1 things. It writes about scientific matters.  
2 Science after all is discussed outside of  
3 peer-reviewed articles, you know. It's discussed  
4 and debated and this is in addition to that debate  
5 that I was invited to contribute.

6 Q. Let's go to page 501 of the article and  
7 let's zoom in to the second-to-last paragraph,  
8 please. We're just going to read the last sentence  
9 of that paragraph.

10 "It was my intention when I arrived in  
11 Baltimore in 1975 to help end it." Did I read that  
12 correctly?

13 A. You did, yes. Mm-hmm.

14 Q. And it is in reference to sexual  
15 reassignment surgery; is that right?

16 A. That's right, yes.

17 Q. Okay. So is it safe to say that you had  
18 already made up your mind to end the provision of  
19 this care when you arrived at Johns Hopkins in '75?

20 A. No. No, that's not correct. It is --  
21 it's -- what this really means is when I came to

1 avoid what they had undergone, I would have done  
2 that. So anyway, there you go.

3 Q. Why weren't you impressed?

4 A. Well, as I said, I thought they were --  
5 they were men masquerading as women.

6 Q. Did you speak with these patients?

7 A. Yeah. Yes, I did. But, you know, not  
8 more than -- I was -- I was the director of the --  
9 of the department there and I was being shown these  
10 by a member of the department.

11 Q. Had you looked into the literature at the  
12 time --

13 A. I had -- no, it -- it was my -- it was my  
14 first encounter with this. Ira Pauly, who was the  
15 -- who was the most distinguished psychiatrist out  
16 there, was working on picking up on this idea and  
17 was showing some of the patients. They did it at  
18 their grand rounds there and I was, as I said, not  
19 impressed that these patients had been benefited.  
20 Mm-hmm.

21 Q. And you haven't conducted any independent

1 research of your own into the efficacy of sex  
2 reassignment surgery at the time?

3 A. No, I didn't. No. But it was already  
4 going on at Hopkins when I arrived and I encouraged  
5 it.

6 Q. Later in the article, if we go to page  
7 503 --

8 A. Yes.

9 Q. -- I think it's third-to-last  
10 paragraph --

11 A. Yeah.

12 Q. -- I'm going to read that first sentence.  
13 "Moral matters should have some salience here."

14 A. Yes.

15 Q. Did I read that correctly?

16 A. Yes. Yes.

17 Q. What did you mean by that?

18 A. Well, let me just get it again. Where --  
19 where is it? I -- I know I said that, but I can't  
20 find it. So I know if it is --

21 Q. Sure. Yes. We can -- can you see my --

1 the cursor?

2 A. Yes, I can see your cursor. No, I can't  
3 see your cursor. Let me -- I mean, I know it's in  
4 here. I -- yeah, there it is. "Moral matters..."  
5 Yes, I've got it. Yeah, "...should have some  
6 salience here." Yes. What do you want to know?

7 Q. What did you mean by that?

8 A. Well, I followed on with it, didn't I? I  
9 said "These include the waste of human resources,  
10 the confusions imposed on society where men and  
11 women insist on acceptance, even in athletic  
12 competitions with women, the encouragement of the  
13 illusion of technique, which assumes that the body  
14 is like a suit of clothes."

15 All of those are -- and finally, the  
16 ghastliness of the mutilated anatomy. All of those  
17 are moral matters.

18 Q. Do you think moral concerns should affect  
19 whether somebody is able to obtain care?

20 A. Excuse me. I'm -- I'm not sure I  
21 understand that.

1           Q.     Did he have -- did he share the same  
2 concerns that you had?

3           A.     No.   He was very sure that he was doing  
4 -- the exercises that he was doing were -- were  
5 only beneficial.   Yeah.

6           Q.     In the just under 50 years since you've  
7 became psychiatrist-in-chief, you, yourself, have  
8 not sought to conduct any primary research to  
9 address the concerns that you have; is that right?

10          A.     No.   That's right.

11          Q.     And you -- who made the decision to stop  
12 providing medical and surgical care at Johns  
13 Hopkins?

14          A.     Well, it -- it was -- I suppose it was a  
15 departmental-wide decision, but of course I led  
16 that because I was leading the department.   So I in  
17 looking at the Meyer data that came along, I said  
18 that I didn't think that we should continue it.  
19 And so we stopped.

20          Q.     And did you advocate against its  
21 reopening while you --

1 and followed on after the Meyer study seemed to  
2 confirm and, in fact, enhance what the Meyer study  
3 had demonstrated.

4 Q. And to which Swedish study are you  
5 referring to?

6 A. The -- the John Meyer and Ryder study  
7 that was done in 1979.

8 Q. Sorry. That's the Meyer study?

9 A. Yes.

10 Q. But you mentioned a --

11 A. Yes.

12 Q. -- a Swedish -- a Swedish study.

13 A. A Swedish study, Dhejne's study, that  
14 followed for 30 years the people treated with  
15 transgender surgery in Sweden.

16 Q. The Dhejne study that was published in  
17 2011; is that right?

18 A. That's right. That's the one. Yes, sir.

19 Q. Okay. What do you believe that the  
20 Dhejne study showed?

21 A. It showed that the -- that the patients

1       that had the transgender surgery, their suicide  
2       rate was 19, close to 20 times the general  
3       populations and that they had a -- a variety of  
4       further troubles that began about 10 years after  
5       the surgery.

6           Q.     That was comparing the transgender  
7       population postsurgery to the general population at  
8       large; is that right?

9           A.     That's right. Yes.

10          Q.     Wouldn't the apt comparison for the  
11       conclusion to which you are referring, would it  
12       have been comparing postsurgical patients with  
13       presurgical patients?

14          A.     Well, it -- it would have been, but they  
15       didn't do that. But after all, the Meyer study did  
16       compare patients with other patients and the  
17       Branstrom study did the same afterwards.

18           But the, you know, the Dhejne study was  
19       powerful in the fact that it really did do what one  
20       wanted, namely do a complete follow-up of  
21       everybody.

1           Q. And -- but the Dhejne study only shows  
2 that transgender people even after surgery have a  
3 higher incidence of suicide when compared to the  
4 general population at large. That's all that it  
5 showed; is that right?

6           A. That's something, isn't it?

7           Q. Well, I wouldn't be surprised by that.  
8 Wouldn't --

9           A. Twenty times? Nineteen times more? Oh,  
10 you'd be surprised by that, Dr. Gonzalez.

11          Q. Wouldn't it be -- wouldn't it be -- I  
12 wouldn't be surprised given the social  
13 stressors. So I guess my question is: Wouldn't it  
14 be an alternative hypothesis that that difference  
15 compared to the general population at large is due  
16 to social stigma, oppression, and/or  
17 discrimination?

18          A. Yeah, you'd think that and particularly  
19 in other countries besides Sweden. Sweden is a  
20 very accepting country. You know, this social  
21 pressure or social stigma argument is being used to

1 -- to justify this thing, but it -- I must say I  
2 don't see it as powerful as people claim. But, you  
3 know --

4 Q. But it is still an alternative  
5 hypothesis?

6 A. Oh, it's an alternative hypothesis and it  
7 needs to be studied. Absolutely. But meanwhile we  
8 probably should stop if 20 times suicide  
9 continues. It's not doing people a lot of good.

10 Q. Well, how do you know that it's not doing  
11 good? It didn't -- it didn't do a comparison pre  
12 and postsurgical?

13 A. It's not doing good because it's evident  
14 that it's not doing good yet and it's up to them to  
15 show where the evidence -- where the good is and we  
16 didn't find any good out -- out of the Meyer study.

17 Q. Okay.

18 A. You see, it was -- it was -- you know,  
19 the -- the fact that the Meyer study showed that  
20 the patients really weren't better in the claims --  
21 in the things that they claimed that they would be

1       discovered in doing this and it was very  
2       unexpected. No one expected to find a 20 times  
3       increase in suicide amongst those patients. They  
4       would never have started this treatment if they  
5       were going to find that result.

6           Q. Are you aware that Cecilia Dhejne has  
7       said that that is a mischaracterization of her  
8       study?

9           A. I -- I'm very well aware of it that, you  
10      know, that's what her claim is, but this is what  
11      anyone who reads the data would ordinarily feel.

12          Q. You say anyone who would read the data.

13          A. Yes. Yes.

14          Q. Are you aware that multiple people have  
15      read the data and do not come to that same  
16      conclusion?

17          A. Yes, I am aware of that.

18          Q. Okay.

19          A. But they were not looking closely at what  
20      the implications might be in my opinion. In my  
21      opinion they did not carefully and -- think about

1       their role in -- their role as doctors. They were  
2       not --

3           Q. I don't -- I don't mean to be combative  
4       with these questions.

5           A. No, that's fine. That's fine.

6           Q. But I -- are you saying that the only way  
7       that somebody would have -- the only way to prove  
8       that somebody looked at the data is that they came  
9       to the same conclusion as you did?

10          A. Well, it's close to that. It seems to me  
11       this is so -- this is almost black and white,  
12       Mr. Gonzalez, it seems to me. But you know,  
13       obviously people are disagreeing, but I think  
14       they're disagreeing because of the social pressures  
15       that are felt still. I -- I -- I don't --

16          Q. Well, you're quoting the author, right?

17          A. I don't know -- I don't know how many  
18       other bodies have to accumulate before people start  
19       -- start saying, you know, this isn't a good idea,  
20       but it will -- it will come.

21          Q. What is the incidence of suicide for

1       would want in talking with my endocrine colleagues  
2       to talk about that matter.

3                 Because it turns out that the use of --  
4       of puberty blockers seems to alter the ultimate  
5       results of patients, young children, with gender  
6       dysphoria. The majority of them, 70 to 80 to 90  
7       percent of them, lose this gender dysphoria going  
8       through puberty and therefore are not interested in  
9       cross-sex hormones or surgery; whereas, once you  
10      start them on this, puberty blockers, almost 90  
11      percent of them go the whole way it seems.

12               At any rate, that's the -- that's the  
13      present data that I know and that means to me that  
14      something has organized them or reorganized their  
15      brain or made them at least more suggestive to  
16      further treatment that comes along with accepting  
17      the treatment of the -- of the puberty blockers.

18               And that may be simply a psychologically  
19      phenomena, but it may well be a biological  
20      phenomenon demonstrating that some of the  
21      reversibility that's claimed doesn't happen. But

1           Q.     Do you know what studies were being  
2 referenced in the DSM-5?

3           A.     I -- I have no idea, but I think there  
4 are several.

5           Q.     Do you know that those studies have to do  
6 with children diagnosed with gender identity  
7 disorder as opposed to gender dysphoria?

8           MR. KNEPPER: Objection; form.

9           THE WITNESS: I'm -- I'm not sure I  
10 understand the difference there --

11 BY MR. GONZALEZ-PAGAN:

12           Q.     Well --

13           A.     -- that you're trying to draw.

14           Q.     -- would you agree that the gender  
15 identity disorder diagnosis is distinct from the  
16 gender dysphoria diagnosis?

17           A.     Yeah. Well, I agree that in DSM they are  
18 trying to make that distinction and I'm not sure I  
19 understand it. And I don't think it's necessarily  
20 valid.

21           Q.     It could be that some of the children

1 diagnosed with gender identity disorder were indeed  
2 simply not transgender to begin with?

3 MR. KNEPPER: Objection; form.

4 BY MR. GONZALEZ-PAGAN:

5 Q. Would you agree that there -- that an  
6 alternative --

7 A. I believe -- I believe they're all  
8 capable of -- of changing and as far as I know,  
9 nobody is making these distinctions that you are  
10 trying to draw here for me.

11 And I know that these patients, these  
12 subjects rather, if let alone, they desist. But  
13 they are to begin with and how they are distinct is  
14 for somebody else to show me, okay.

15 But as far as I know, the evidence right  
16 now is to say if somebody says they don't -- their  
17 -- their sex of opinion and the sex of their body  
18 are discordant -- discordant, they change and  
19 become concordant in 80 to 90 percent of the cases  
20 if they're allowed to go through puberty. That I  
21 know.

1 purpose. Its purpose is over, okay. It's -- that  
2 purpose has been settled. We can go on now and  
3 should be using more intelligible, coherent  
4 approaches to classification than a field guide.

5 Q. Do you -- in speaking about this 70 to 80  
6 percent statistic just now, you made reference to  
7 the word change, that these children were able to  
8 change from their cross-gender identification, did  
9 you not?

10 A. Did I use the word change? Well, they  
11 abandoned it.

12 Q. I believe you did, but I'm asking you.

13 A. Well, what I -- what I just meant was  
14 that they abandoned the idea that they were somehow  
15 in the wrong sex. They were the -- you know, their  
16 sex of opinion and their sex of the body were  
17 misaligned.

18 Q. Do you believe that transgender patients  
19 should be encouraged to align their identity  
20 and presentation with the sex they were determined  
21 at birth?

1           A.    Wouldn't you?  Wouldn't that spare them a  
2 long lifetime of hormone treatments and constantly  
3 dealing with doctors and things of that sort?  
4 Finding themselves to be what they were born --  
5 they were made in conception.  Oh, yes, I think  
6 that this -- that would -- if we could do that, we  
7 would all do that.

8           Q.    Do you believe that that's effective?

9           A.    I think that it would be.  I think it  
10 would be effective and I think going through  
11 puberty is one of the ways that they -- that those  
12 kinds of things come back into alignment.

13          Q.    I guess what I'm asking is:  You oppose  
14 the provision of hormonal and surgical care for the  
15 treatment of gender dysphoria, you have noted  
16 throughout that -- that your clinic -- that the  
17 clinic at Johns Hopkins continued to provide  
18 psychiatric care, and I guess what I'm wondering is  
19 what is the psychiatric care that you believe  
20 should be provided to transgender people --

21          A.    Yes.

1 Q. -- with gender dysphoria?

2 A. Well, it depends on various kinds of  
3 sources of their transsexual feelings, but amongst  
4 young children I think that there should be family  
5 therapy that looks into the reasons why the person  
6 is dissatisfied with their sex at conception.

7 Q. And --

8 A. And often you'll find that there are  
9 other kinds of other sources of discouragement,  
10 depression, and sometimes abuse, sexual abuse,  
11 things of this sort. And those things should be  
12 dealt with. Those should be dealt with  
13 psychologically.

14 Q. And if the young person persists in their  
15 cross-gender identification into adults and  
16 adulthood, what then?

17 A. Well, they can do whatever they please.

18 Q. Except --

19 A. I -- I would --

20 Q. -- get hormonal and medical care?

21 A. But I -- I think that they -- you know, I

1 -- I think that if they persist -- we have -- we  
2 have lots of disorders of assumption that appear in  
3 adolescence and persist into adulthood, but we  
4 still try to help people with them. The best  
5 example being anorexia nervosa.

6 It is a condition that springs up usually  
7 amongst young women in their early teens and -- but  
8 it can extend right into long life with people and  
9 they often need counseling and support to get them  
10 to eat satisfactorily enough to keep them at least  
11 reasonably healthy even though they continue to  
12 have the fear of fatness that is fundamental to  
13 this. This is -- this is not new, that -- it would  
14 -- it would continue.

15 Q. What's the goal of the therapy?

16 A. What's the role of the therapy?

17 Q. The goal.

18 A. The goal --

19 Q. What's the goal of the therapy?

20 A. The goal of the therapy is explain to the  
21 patients right off the bat is to lead them to move

1 from an idea that is unreal to the reality world  
2 that they need to live in and they should live in.

3 Q. I guess to clarify --

4 A. And that they would flourish -- they  
5 would flourish better if they did that we think.

6 Q. Just to clarify, when you talk about  
7 shifting from the idea to the real, do you mean to  
8 align their identity with the sex that they were  
9 determined at birth?

10 MR. KNEPPER: Objection; form.

11 THE WITNESS: Once again, the sex was --  
12 was --

13 BY MR. GONZALEZ-PAGAN:

14 Q. That's semantics, but --

15 A. -- received at conception. Their sex was  
16 -- has been from conception. Let's call it --  
17 let's just call it for the sake of argument natal  
18 sex, okay? That's fair enough.

19 Q. Great.

20 A. We can do that.

21 Q. Fair enough. We'll use that terminology.

1           A. I think -- I think people do better and  
2 live better and flourish better and need less help  
3 from -- from doctors if their natal sex and their  
4 attitude towards their -- their own sex is the  
5 same.

6           Q. Are you aware that the American  
7 Psychiatric Association opposes conversion therapy  
8 efforts?

9           A. Oh, I know the American Psychiatric  
10 Association -- its -- its views about any of these  
11 conversion therapies and I think that we often  
12 mistake the idea that -- that -- this is something  
13 that we're trying to force on patients or something  
14 that we're trying to do for their benefit, you  
15 know.

16           Q. Okay.

17           A. I think the benefit of patients is that  
18 they -- they do better the more they're aligned  
19 with reality, not what is possibly true. It's true  
20 regardless of whether anyone believes it or not.

21           MR. GONZALEZ-PAGAN: Lauren, let's look

1           A. I do, yes, sir. Yeah.

2           Q. Okay. And it is titled Transgender,  
3 Gender Identity, and Gender Expression  
4 Non-Discrimination. Do you see that?

5           A. I do. I do see that. Yeah.

6           MR. GONZALEZ-PAGAN: If you go to -- give  
7 me one moment. I apologize, Lauren. This is the  
8 wrong resolution. There's two. Let's introduce  
9 the other one. We'll leave this one marked as 11.

10          MS. EVANS: Sorry about that.

11          MR. GONZALEZ-PAGAN: That's okay.  
12 They're both called APA resolutions.

13          MS. EVANS: Give me a second. Hopefully  
14 this is the right one.

15          MR. GONZALEZ-PAGAN: Yes.

16           (Whereupon, Exhibit No. 12 was marked for  
17 identification.)

18 BY MR. GONZALEZ-PAGAN:

19          Q. Dr. McHugh, I'm showing you what's been  
20 marked as Exhibit 12. Do you see that?

21          A. Yes. Okay. Yes. Right.

1           Q.    Okay.  And it is a resolution by the  
2 American Psychological Association --

3           A.    Yes.

4           Q.    -- on gender identity change efforts.  Do  
5 you see that?

6           A.    I do.  I see that, yes.

7           Q.    Okay.  And it is dated February  
8 2021.  All right.  Let's go to the second page and  
9 zoom in at the bottom.

10          A.    Yeah.

11          Q.    On the third-to-last paragraph in that  
12 second column, one of the whereas statements, it  
13 states "Whereas, GICE have not been shown to  
14 alleviate or resolve gender dysphoria (Bradley and  
15 Zucker, 1997; Cohen-Kettenis and Kuiper, 1984;  
16 Gelder and Marks, 1969; Greenson, 1964; Pauly,  
17 1965; and SAMHSA, 2015)" Did I read that  
18 correctly?

19          A.    Yes.  Yes.

20          Q.    Do you understand GICE to mean gender  
21 identity change efforts?

1           A.    Yeah.

2           Q.    Okay. And the American Psychological  
3 Association is citing to a number of scientific  
4 articles in support of that statement that they  
5 make there; is that right?

6           A.    Yes.

7           Q.    Okay. Including one by Ira Pauly --

8           A.    Yes.

9           Q.    -- that you earlier discussed?

10          A.    Yes. Yes.

11          Q.    And including one by Ken Zucker; is that  
12 right?

13          A.    Yes. Yes. I see that, yes. It's very  
14 interesting that -- that he would be quoted in that  
15 given that he has demonstrated that with 25  
16 patients -- he studied children, young people, with  
17 gender or sex disorder -- that 24 or 25 of them he  
18 was able to alleviate. So I'm -- I'm surprised to  
19 see that. Anyway...

20          Q.    And Ken Zucker believes that once a  
21 patient has persisted into adolescence and

1 adulthood, they should have access to hormonal and  
2 medical treatment; is that right?

3 A. Yes.

4 MR. KNEPPER: Objection.

5 THE WITNESS: Yes. Yes, he does. Yeah.

6 BY MR. GONZALEZ-PAGAN:

7 Q. Let's go to page three, the last two  
8 paragraphs, the first "Be it therefore resolved..."  
9 It states "Be it therefore resolved that consistent  
10 with the APA definition of evidence-based practice  
11 (APA, 2005) the APA affirms that scientific  
12 evidence and clinical experience indicate that GICE  
13 put individuals at significant risk of harm."

14 A. Yes.

15 Q. "Be it further resolved that the APA  
16 opposes GICE because such efforts put individuals  
17 at significant risk of harm and encourages  
18 individuals, families, health professionals, and  
19 organizations to avoid GICE." Did I read that  
20 correctly?

21 A. You did.

1           Q.     Okay.  Is it fair to say that the  
2 American Psychiatric Association and the American  
3 Psychological Association both oppose therapeutic  
4 efforts to change a person's gender identity?

5           MR. KNEPPER:  Objection; form.

6           THE WITNESS:  Yes.  Yes, that's right.

7 BY MR. GONZALEZ-PAGAN:

8           Q.     And that -- is it fair to say that the  
9 American Psychiatric Association and the American  
10 Psychological Association both consider such  
11 efforts to be unethical and harmful?

12           MR. KNEPPER:  Objection; form.

13           THE WITNESS:  That -- that's what they  
14 say here.

15 BY MR. GONZALEZ-PAGAN:

16           Q.     Thank you.  All right.  Let's go to --  
17 let's show you your report again, Dr. McHugh.

18           A.     Okay.

19           Q.     Let's go to paragraph 10 of your report  
20 on page 12.

21           A.     Yes.